

Claim notification form

Personal liability/Buildings liability

As the insured person or their legal representative, please complete the form in full and send it to the address given on the last page. Only then can we verify your entitlement to benefits.
Any questions? Our Customer Service Centre will be happy to help on 0844 277 888. Thank you.



Alternatively, you can notify us online at css.ch/liability

Client number

1 General information

1.1 Insured person

First name	Surname	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>

Street, house number	Postcode/town
<input type="text"/>	<input type="text"/>

1.2 Contact

Home phone	Mobile phone	Business phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

What is the best time to reach you?	Where?	<input type="checkbox"/> Home	<input type="checkbox"/> Mobile	<input type="checkbox"/> Business	Email
<input type="text"/>					<input type="text"/>

2 Information on the loss event

2.1 Date/place of loss/damage

Date	Time
<input type="text"/>	<input type="text"/>

Street, house number	Postcode/town
<input type="text"/>	<input type="text"/>

2.2 Cause of damage/course of events

2.3 Who caused the damage/loss?

First name	Surname	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Street, house number	Postcode/town	
<input type="text"/>	<input type="text"/>	
Home phone	Mobile phone	Business phone
<input type="text"/>	<input type="text"/>	<input type="text"/>
What is the best time to reach you?	Where? <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Business	Email
<input type="text"/>	<input type="text"/>	<input type="text"/>
Occupation	Employer	
<input type="text"/>	<input type="text"/>	

2.4 Is any other person partly to blame?

Yes No

If yes, who?

First name	Surname	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Street, house number	Postcode/town	
<input type="text"/>	<input type="text"/>	

3 Notification of police

3.1 Person who notified police

First name	Surname	
<input type="text"/>	<input type="text"/>	
Street, house number	Postcode/town	
<input type="text"/>	<input type="text"/>	
Date reported	Police station	Police officer
<input type="text"/>	<input type="text"/>	<input type="text"/>

3.2 Police report drawn up?

Yes No

3.3 1st witness

First name	Surname	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>
Street, house number	Postcode/town	
<input type="text"/>	<input type="text"/>	

Please list additional witnesses on a separate sheet of paper.

4 Third-party property damage

4.1 Injured party (owner of an object/a building)

First name	Surname	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Street, house number	Postcode/town	
<input type="text"/>	<input type="text"/>	
Home phone	Mobile phone	Business phone
<input type="text"/>	<input type="text"/>	<input type="text"/>
What is the best time to reach you?	Where? <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Business	Email
<input type="text"/>	<input type="text"/>	<input type="text"/>

Damage/loss/damaged objects

Nature of damage/loss		
<input type="text"/>		
Age of object	Place of inspection	Loss amount
<input type="text"/>	<input type="text"/>	<input type="text"/>

Are the items named above covered by any other insurance policies?

<input type="checkbox"/> Partial cover	<input type="checkbox"/> Fully comprehensive	<input type="checkbox"/> Fire	<input type="checkbox"/> Theft
<input type="checkbox"/> Glass breakage	<input type="checkbox"/> Water damage	<input type="checkbox"/> Valuables	<input type="checkbox"/> Liability
<input type="checkbox"/> Other, which	<input type="text"/>		

With which insurance company?	Policy no./claim no.	Was the case notified to them?
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
With which insurance company?	Policy no./claim no.	Was the case notified to them?
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list additional injured parties on a separate sheet of paper.

5 Damage to rental property by tenant

5.1 Lease term (Please enclose record of handover)

Date lease begins	Date lease ends	Date of last renovation
<input type="text"/>	<input type="text"/>	<input type="text"/>

6 Injured persons

6.1 Injured person

First name	Surname	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Street, house number	Postcode/town	
<input type="text"/>	<input type="text"/>	
Home phone	Mobile phone	Business phone
<input type="text"/>	<input type="text"/>	<input type="text"/>
What is the best time to reach you?	Where? <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Business	Email
<input type="text"/>	<input type="text"/>	<input type="text"/>
Occupation	Employer	
<input type="text"/>	<input type="text"/>	

Injury

Nature of injury
<input type="text"/>

Attending doctor/hospital

First name

Surname

Hospital

Street, house number

Postcode/town

Where is the injured person insured against accident?

Name of insurance company

Policy no. /claim no.

Please list additional injured parties on a separate sheet of paper.

7 Claims for damages

7.1 Have any claims for damages been made against you?

Yes No

If yes, by whom?

First name

Surname

Street, house number

Postcode/town

8 Supplementary question

8.1 Do you live with the injured person in the same household?

Yes No

8.2 Are you related to the injured person?

Yes No

9 Payment to

9.1 Name and address of the recipient

First name

Surname

Street, house number

Postcode/town

9.2 Account details of the recipient

IBAN

Name of financial institution

10 Confirmation

10.1 I/We have legal protection insurance

Yes No

If yes, with which company?

Name of insurance company

Policy no. /claim no.

Comments

The undersigned person hereby confirms that he or she has answered all questions on all pages truthfully and in full.

No claims of any kind may be recognised without the permission of CSS.

CSS Versicherung AG processes the data you disclose to us or which we obtain from third parties with your consent to the extent necessary for handling claims. You hereby agree that the data may be passed on, to the extent required, to the CSS Group companies involved in settling the claim, to co-insurers and reinsurers, authorities and other third parties in Switzerland and abroad for processing or that it may be procured by them. The data will be processed in electronic or paper form. The data is filed for as long as is necessary for business purposes or as laid down by law.

By signing the claim notification form, the undersigned authorises CSS to share information and obtain such at any time from doctors, other service providers, social and private insurers and authorities, and its company doctors and medical advisors to the extent necessary to assess the insurance cover while respecting statutory provisions on data protection. In such cases, all parties involved are released from the obligation to maintain professional secrecy or patient confidentiality with respect to CSS.

You can find further details of the processing of your data in the CSS Versicherung AG privacy policy at css.ch.

The undersigned person is entitled to request information about the data pertaining to him or her that is being processed. Consent to the processing of data may be revoked at any time.

Legal entity for basic insurance (KVG): CSS Kranken-Versicherung AG, legal entity for supplementary insurance (VVG): CSS Versicherung AG

Place

Date

Signature of the insured person or his or her legal representative

Address of the insurer:

CSS, Special Insurance Competence Centre, P. O. Box 2568, 6002 Lucerne